SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PROPOSED ACTION – MEDICAL ASSISTANCE ONLY

FROM:
SCDHHS - Central Mail
PO Box 100101
Columbia, SC 29202
(888) 549-0820 (TTY 888-842-3620)

DATE: _____

BUDGET GROUP NUMBER: _____

TO:

PLEASE READ THE STATEMENTS CHECKED "X" BELOW FOR INFORMATION ABOUT YOUR ASSISTANCE.

TYPE OF ASSISTANCE RECEIVED: _____

NOTICE: If your circumstances change, you have an increase or decrease in income or you have new or additional information that would affect your case, it is your responsibility to notify the Department of Health and Human Services within ten (10) days.

☐ **The monthly amount you pay to the medical facility will change from $_____ to $_____ beginning _____.**

☐ **The monthly amount you pay to the medical facility will be $_____ beginning _____.**

☐ **Community Long Term Care (CLTC) has informed the Department that your level of nursing care will be changed from _____ to _____ beginning _____. The nursing care facility in which you reside does not provide both skilled and intermediate level care in the same area. Therefore, you should be sure that you are transferred promptly to the area of your present facility or to a different nursing care facility that will provide you with the level of care appropriate to your needs. The Department will terminate its Medicare coinsurance or Medicaid vendor payment on _____ unless you are placed in the proper level of care.**

☐ **CLTC has informed the Department that you will be eligible for _____ level nursing care upon termination of your Medicare benefits; therefore, a Medicaid vendor payment will be made to the nursing care facility in your behalf.**

☐ **Your eligibility for a vendor payment made to a medical provider in your behalf, by the department, will be discontinued beginning _____.**

Reason for Action:

MANUAL/POLICY REFERENCE SUPPORTING THIS ACTION (A copy of the referenced material is available upon request from the county department):

_____

☒ **FAIR HEARING:**

If you feel that DHHS has made an error in processing your case, you have the right to appeal this decision at a hearing with SCDHHS. You may represent yourself at the hearing, hire an attorney to help you or have someone speak on your behalf. You must submit a written request for a hearing no later than 30 calendar days from the date on this notice via one of the following methods:

- **Online at www.scdhhs.gov/appeals**
- **Fax your request to: 888-835-2086**
- **Mail your request to:**
  SCDHHS – Central Mail
  PO Box 100101
  Columbia, SC 29202-3101
  Attn: Eligibility Appeals
- **Email to: eligappeals@scdhhs.gov**

In your appeal request, you should specifically state which issue(s) you wish to appeal and attach a copy of the notification received from SCDHHS regarding the specific matter on appeal. For more information about the appeal process or what to include in your appeal request, go to www.scdhhs.gov/appeals, call 888-835-2039 or send an email to eligappeals@scdhhs.gov.

If you submit an appeal request within 10 days of the date on this notice, you may be eligible to continue to receive Medicaid benefits until a decision is made regarding your appeal. If you decide to continue receiving benefits during your appeal, you may be asked to repay any charges to your Medicaid account if the appeal decision is not in your favor.

☐ **NOTICE**

If your circumstances change, you have an increase or decrease in income or you have new or additional information that would affect your case, it is your responsibility to notify your Department of Health and Human Services within ten (10) days.

☐ **STATE RETIREMENT**

If your Medicaid is being terminated because you have been discharged from a nursing home and you receive State Retirement benefits, you must contact the South Carolina State Retirement System at the end of six (6) months from your date of discharge if:

1. **You have not been admitted to a nursing facility or,**

2. **You have not been admitted to a hospital. You may be eligible to receive an increase in your State Retirement check.**

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact Janet Bell, ADA and Civil Rights Official, by mail at: PO Box 8206, Columbia, SC 29202-8206; by phone at: 1-888-549-0820 (TTY: 1-888-842-3620); or by email at: civilrights@scdhhs.gov.

If you believe that SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person or by mail or email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Language Services

If your primary language is not English, language assistance services are available to you, free of charge. Call: 1-888-549-0820 (TTY: 1-888-842-3620).

si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-549-0820 (TTY: 1-888-842-3620).

أذا كانت لغتك الاساسية غير اللغة الانكليزية فان خدمات المساعدات اللغوية متوفرة لك مجانا.اتصل على الرقم:

888-549-0280(رقم هاتف الصم والبكم 1-888-842-3620)

Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-549-0820 (TTY: 1-888-842-3620).

Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-549-0820 (телетайп: 1-888-842-3620).

Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-549-0820 (TTY: 1-888-842-3620).

Se você fala português do Brasil, os serviços de assistência em sua lingua estão disponíveis para você de forma gratuita. Chame 1-888-549-0820 (TTY : 1-888-842-3620)

如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-549-0820 (TTY: 1-888-842-3620)

Falam tawng thiam tu na si le tawng let nak asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in na ko thei.

धयद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-888-549-0820 (TTY: 1-888-842- 3620) पर कॉल कर।

한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-549-0820 (TTY: 1-888-842-3620)번으로 전화해 주십시오.

Haka tawng thiam tu na si le tawng let asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in ko thei.

Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 888-549-0820 (ATS : 888-842-3620).

နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤန့်၊ ကျိာ်အတၱ်မၤစၢၤလၢ တလာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 888-549-0820 (TTY: 888-842-3620)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-549-0820 (መስማት ለተሳናቸው: 1-888-842-3620).

အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့် င့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 888-549-0820 (TTY: 888-842-3620) သို့ ခေါ် ဆိုပါ။